

CALIFORNIA LOW COST AUTOMOBILE INSURANCE PROGRAM

Policy Change Request - Certification Form

CURRENT POLICY INFORMATION

Named Insured _____

Mailing Address _____

Policy Number _____ Name of Insurer (If known) _____

Producer Name _____ License No. _____ Telephone No. _____

Change is for a: ☐ New application ☐ In force policy Requested Effective Date : _____

CHANGE REQUEST

1. Please change my address from the mailing address listed above to my new address of:

2. Please replace my current vehicle with the following vehicle: ☐ Copy of Registration is Attached.

| Year | Make | Model | VIN |
|------|------|-------|-----|
| | | | |

3. ADD/DELETE the following driver(s): ☐ Copy of Driver's License is Attached

| First Name | Last Name | CA Driver's License # | Relationship | Add/Delete |
|------------|-----------|-----------------------|--------------|------------|
| | | | | |
| | | | | |

4. ADD/DELETE the following coverage(s): Medical ☐ Add ☐ Delete UMBI ☐ Add ☐ Delete

5. Other Change(s): _____

INSURED CERTIFICATION SECTION

I, the named insured of the above policy, under penalty of perjury, hereby certify to the best of my knowledge that:

- ☐ I continue to meet the eligibility requirements for the California Low Cost Automobile Insurance Program.
☐ I no longer meet the eligibility requirements for the California Low Cost Automobile Insurance Program for the following reason(s):

I understand that Low Cost Auto policy coverage will continue until expiration of the policy. The insurer will provide notice of non-renewal as required by the California Low Cost Automobile Insurance Program Manual rules.

SIGNATURE OF NAMED INSURED: _____ DATE/TIME _____

SIGNATURE OF PRODUCER: _____ DATE/TIME _____